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ABSTRACT

This brief is part of a series of technical assistance resources on financing and sustaining out-of-school time and community school initiatives. The brief presents general background information and strategies for maximizing Medicaid funding for such programs and highlights examples of innovative projects throughout the country. The financing strategies described are: (1) fee-for-service claiming; (2) administrative claiming; (3) "leveraged" funding, or partnerships that maximize Medicaid reimbursements; and (4) building statewide systems to integrate services and improve outcomes. (EV)

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Maximizing Medicaid Funding to Support Health and Mental Health Services for School-Age Children and Youth

Strategy Brief

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TOOLS FOR OUT-OF-SCHOOL TIME AND COMMUNITY SCHOOL INITIATIVES

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The FINANCE PROJECT

Maximizing Medicaid Funding to Support Health and Mental Health Services for School-Age Children and Youth

Strategy Brief

"You cannot educate a child who is not healthy, and you cannot keep a child healthy who is not educated."

—Dr. Jocelyn Elders, Former U.S. Surgeon General

By Andrew L. Bundy with Victoria Wegener

Over the past several years, increasing public attention, local and national policy debate, and private and public sector funding have focused on developing high quality programs for children and families during non-school hours. In a related and promising development, community school initiatives—sometimes called "full service schools" or "extended service schools"—are increasingly offering services and resources to children and families in public school buildings, during school hours, before and after school, on weekends, and during the summer.

Out-of-school time and community school initiatives have emerged as two of the more dynamic strategies for ensuring children's success, strengthening families, improving schooling, and building communities. Simultaneously, recent federal emphasis on promoting early and preventative health care for low-income families has increased opportunities for providing health and mental health services to school-age children and youth. Combined, these factors create the possibility of an expanded, dynamic role for health and mental health services in initiatives serving school-age children and youth.

As the nation's strongest financial commitment to ensuring the health and mental health of poor children, Medicaid represents a significant potential source of funds for expansion and improvement of mental health and health services in initiatives serving school-age children and youth. Wherever a Medicaid-eligible child receives a Medicaid-eligible service from a Medicaid-certified provider—the costs of that service are reimbursable by federal and state agencies. Moreover, unlike many other federal programs, Medicaid is an entitlement program. This means that it is not subject to a spending cap; as long as claims filed by local agencies meet the requirements of the state and federal agencies who administer Medicaid, there is no limit on the funds that can be paid out. Nor is Medicaid a competition in which a few fortunate grantees receive funding and other applicants are refused support. Finally, when programs draw down Medicaid funds to pay for existing services which were previously supported with other local or state funds, these funds can be freed up for other work, making possible program expansions and other improvements in the quality of service.

Accessing Medicaid funding is not easy. As one of the largest federal funding sources for services for children and families, Medicaid financing is complex, bureaucratically dense, and subject to policy debates and frequent changes in rules and procedures. When Medicaid financing is approved, the administrative and record-keeping tasks are often considerable. In general, administrators, policy makers and program developers must be prepared to spend considerable time organizing and facilitating the process of accessing Medicaid funding. Anyone using Medicaid funding must also be prepared for the possibility of a federal or state audit.

While difficult to access, Medicaid has great potential as a source of revenue for health and mental health services for school-age children and youth. The pro-

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grams and approaches profiled in this brief are on the cutting edge of a strategy that could soon be growing rapidly. Such growth is not a certainty, however. Few well-established examples of Medicaid funding for out-of-school time and community school health or mental health programming exist. This relative scarcity is partly a function of the logistical and practical challenges involved, but it also speaks to the historically limited and tenuous links between school-based programming and health and mental health services.

The complexity of Medicaid, the level of detail required to establish eligibility, claim funds and manage them effectively, and the innumerable differences between states and their policies are too great to be covered here. This strategy brief presents general background information and strategies for maximizing Medicaid funding, and highlights examples of innovative projects throughout the country. It is hoped that by profiling some of these leading ventures, this brief will encourage providers of mental health, health care, out-of-school time and community school initiatives to come together to craft new efforts that respond to the needs of children and families in their communities.

BACKGROUND AND GENERAL CONSIDERATIONS

The Purpose of Medicaid—Promoting Health in the Broadest Sense. Federal Medicaid law requires that all states provide low-income children with screening, diagnosis and treatment services on a regular "periodic" basis: this is known as Early Periodic Screening, Diagnosis and Treatment, or EPSDT, and it is a virtual health bill of rights for low-income children. The vast majority of the country's poor children are entitled to medical and dental check-ups, hearing and vision screenings, diagnosis of any illnesses, physical or mental, and ongoing treatment for any conditions diagnosed.

Furthermore, the legislative intent of Medicaid is not only to insure children access to health care, traditionally defined, but also to meet children's emotional, mental health, prevention, and early intervention needs. So, for example, after a child has been seen by a doctor or mental health professional for a screening, a prescribed mental health treatment program might include counseling in a therapeutic after-school program, or school-based prevention and early intervention services of other kinds. All of these services—if provided in ways that comply with state and federal regulations—can be eligible for Medicaid reimbursement.

The Three E's: Eligible Services, for Eligible Clients, offered by Eligible Providers. The "three E's" refers to the simple test by which all claims for Medicaid payments are assessed. In order to be reimbursable, a service must be: (1) covered under the State's Medicaid plan; (2) provided to clients who are eligible for Medicaid; and (3) provided by an institution or practitioner that has a Medicaid provider agreement with the state.[1] Medicaid is also generally the payer of last resort; all other available sources must be billed first. Services whose costs can be reimbursed are many—from screening, to dental and vision care, to mental health treatment, to case management. The full list of Medicaid eligible services is long and varied, and can be found at www.hcfa.gov/medicaid/medicaid.htm, the website of the Health Care Finance Administration (HCFA), the federal agency which oversees states' administration of Medicaid and provides federal funds to match state expenditures.

Chronic Under-utilization of Medicaid. Even with a sweeping and inclusive congressional mandate for inclusion of eligible children, under-utilization is characteristic of Medicaid. Only 58 percent of the 22 million eligible children received an EPSDT screening in FY 1997. Political resistance to such government spending, inadequate outreach to eligible families, and reluctance of providers to participate in Medicaid all contribute to this dilemma.

Ambitious Federal Mandate, Powerful State Discretion. Despite the federal government's strong role in framing national guidelines and targets for participation and service delivery, states exercise broad

[1] *Developing Blended Funding Programs for Children's Mental Health Care Systems: A Manual of Financial Strategies*, Susan Edelman, Cathie Wright Center for Technical Assistance to Children's Systems of Care, California Institute for Mental Health, September, 1998.

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control over the character, design, behavior and impact of their Medicaid programs. Indeed, state policy is the single most powerful determinant of Medicaid practices around the country. Variation between states is great.[2] In states whose legislatures, Governors and administrators believe that their best chance of improving children's health care is by accessing increased federal Medicaid funds (often called maximizing revenue), frequent use of innovative Medicaid financing techniques and rising federal Medicaid reimbursements are seen. In states whose leaders are opposed to higher levels of federal spending, where concerns are high that matching requirements may force unacceptable levels of state spending, or where strategies for improved access to health care rely less on a large government role, resistance to Medicaid program expansion can be strong.

Tremendous Funding Potential, Linked to Expertise in Collaboration. Medicaid has the potential to become one of the largest sources of funding for health and mental services in initiatives serving school-age children and youth. As many of the following examples detail, successful Medicaid claiming usually hinges on the ability of two or more agencies to work together cooperatively and with high levels of trust. Such a collaborative, multi-agency, and interdisciplinary approach characterizes many of the best out-of-school time and community school initiatives. Experience in partnering effectively is therefore a major asset in approaching Medicaid financing, since it increases the likelihood that the collaborating agencies will be able to design and implement one of the team-oriented Medicaid claiming options profiled here.

"Costs," "Claims," "Reimbursements" and "Federal Matching Payments." These four terms drive all Medicaid financing, and are worth mastering. While every state will define these terms in a particular way, their core meanings can be distilled, and are constant. *Costs* are the actual expenses incurred by a provider, either in delivering eligible services, such as screening or counseling, or in administering eligible activities, such as outreach to eligible families. *Claims* are the documented requests by providers for state reimbursement for these carefully tracked costs. *Reimbursements* are the state payments of funds to the claiming agencies. *Federal matching payments* are made as matches of state reimbursements. Together, state reimbursements and federal payments can cover some, or all, but never more than, the actual costs incurred. The sequence of these elements is consistent—costs come first, then claims, then state reimbursements, and finally federal matching payments.

Degrees of Flexibility in the Use of Reimbursement and Matching Funds. The fact that Medicaid funding is paid out as a reimbursement or match for the costs of services or administrative work already performed can create an unusual degree of flexibility for the use of state or federal funds, once they are received. For many programs, these funds flow directly back into the program which generated the original costs. State reimbursements and federal matching payments can be used to pay for staffing and activities, enabling the program to sustain itself, and requiring only a short-term, start-up infusion of funds from other sources. For a number of other programs and projects, however, the flow of federal and state Medicaid funds is treated as a means to free up funding—from local, private or state sources. These local funds are then used for other purposes, such as to serve additional children and families, or to create new, enhanced programming for families already receiving services. Finally, the most flexible approach of all is the recognition by some state and local officials that their decisions about the use of federal matching and state reimbursement funds are essentially discretionary. This is the nature of a matching payment or reimbursement—*it is a payment for costs already incurred.* The funds it is replacing have already been spent, and the matching or reimbursement funds received are, legally, for the recipient to do with as it chooses. As the case studies that follow illustrate, this fundamental flexibility is a little understood dynamic that warrants careful study.

[2] In some states, efforts to maximize federal reimbursements with careful investment of state Medicaid spending have been part of policy and planning activity for over a decade. In others, strong philosophical arguments against such planning and state allocations have prevailed, and relatively little federal spending occurs.

Changing Context of Medicaid Policy. Medicaid policy at federal, regional and state levels is in a virtually constant state of flux, creating challenges for any local leaders hoping to access or maximize Medicaid funding for services to school-age children and youth. Many factors contribute to this continuous process of change. Congressional policy initiatives play a large role, like the 1989 mandate for increased enrollment of eligible children, which resulted in significant increases in enrollment nationally, or the 1997 creation of the State Child Health Insurance Program (SCHIP), which has expanded health insurance to children in working families not eligible for Medicaid. Federal administrative actions from the national and regional offices of the Health Care Financing Administration (HCFA) can cause dramatic changes in the rules and practices governing federal matching payments to states, significantly affecting local programming. State changes—in gubernatorial administrations, state legislative policy, or state agency administrative leadership—can lead to a general increase in Medicaid-related financing opportunities, or can result in significantly fewer financing options for local providers. Planners of local services quickly learn to play close attention to the ever-changing mosaic of policies, procedures, and practices—often developing a strong interest in contributing to or otherwise helping to shape such policies, through communication with state legislators or administrators, congressional representatives, or the executive branch of the federal government.

The Challenge for Initiatives Serving School-Age Children and Youth. Several particular challenges face initiative leaders who seek Medicaid funding for their health and mental health work. Initiatives serving school-age children and youth are often non-traditional venues for Medicaid services. In many cities and towns, a set of well-established agencies and institutions already manages existing Medicaid activity. The two most likely future partners and participants in any Medicaid-financed initiative for school-age children and youth—public school systems and mental health providers—often already have firm commitments to pre-existing programs and strategies funded by Medicaid. As the "new kids on the block," those who develop health and mental health services for school-age children and youth may find it challenging to build local and state alliances which enable them to access Medicaid funds.

FUNDAMENTAL PRINCIPLES FOR GETTING STARTED

While those seeking to maximize Medicaid funding clearly face many challeges, the potential payoff is quite substantial. The next sections of this brief demonstrate how focused efforts to maximize Medicaid revenues have yielded large returns for children and youth. The following principles are distilled from the experience and testimony of innovative practitioners from across the country:

- **Know your purpose.** Is your goal to offer more health care services, improve specific outcomes for children, model new programming, sustain existing programming, increase revenue, and/or partner with the Medicaid agency? Think also of the purposes of your prospective partners.
- **Find an expert—or become one yourself.** The complex issues, shifting policies, and multiple, conflicting institutional agendas within Medicaid funding challenge even the most accomplished health administrators and finance managers around the country. Success in accessing and deploying Medicaid funding for health or mental health programming for school-age children and youth will hinge on how diligently you and your team "go to school" on these complex, idiosyncratic processes.
- **Identify, recruit, and partner with leaders in this field.** Don't try to do it without the aid and support of other agencies. Some candidates include:
  - Heads of Medicaid state agencies and staff of local/regional offices of both state and federal Medicaid agencies;
  - Local Medicaid-certified providers;
  - Heads of school systems and other potential partner agencies; and
  - Leaders who are passionate about your work and the outcomes you seek.

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- **Focus on health.** Think about and emphasize the overlap between your initiative and the mission of Medicaid: children's health and mental health, prevention, early intervention, interagency collaboration, and outreach.
- **Use evidence of others' success to make your case.** As you advance your new work, prepare to persuade and encourage any nay-sayers with one or two well-documented examples of successful models in other locales which are similar to the one you are proposing.
- **Anticipate some resistance.** Recognize that this approach has the potential to generate a significant new flow of dollars, which can draw attention, create tension, or stimulate opposition.
- **Keep good records, and be prepared to be audited.** Medicaid, like many federal programs, is subject to rigorous, demanding and frequently updated rules and regulations. Providers often get audited or assessed charges for disallowed payments and claims. Know the rules, seek clarification in the frequent gray areas of policy, and document everything.
- **Assess your institutional readiness and capacity.** Does your organization or initiative have a clear health care or mental health care interest and commitment? Is your organization or a partner agency Medicaid-eligible? Are you ready and willing to commit a year or more of your time to planning and implementing this venture? Is the team of partners sufficiently established and secure to withstand the stresses and challenges of organizing such a time-consuming and labor-intensive project? Does the likely return on this investment of time and energy—in terms of services delivered, reimbursements received, and collaborative enterprises launched—warrant the inevitable human, financial and institutional start-up costs?
- **Consider alternatives.** If your assessment of institutional readiness suggests alternate courses of action, don't despair. Medicaid financing for health and mental health services in initiatives serving school-age children and youth is only one of many approaches to organizing and sustaining these valuable programs for children and families. If the necessary ingredients are not at hand, you will be wise to focus your energies elsewhere, seeking out and maximizing resources through a variety of other means. For some ideas, see the other strategy briefs in The Finance Project series, available at www.financeproject.org/osthome.htm.

FINANCING STRATEGIES

The following section describes four strategies for maximizing Medicaid to support health and mental health services for school-age children and youth: (1) fee-for-service claiming; (2) administrative claiming; (3) "leveraged" funding; and (4) building statewide systems to integrate services and improve outcomes.

The first three strategies are most applicable for program developers who are providing direct services to school-age children and youth. The last strategy is more relevant for community leaders and policy makers looking to improve larger systems of care. This section provides a basic description of each strategy, highlights examples of the strategy in practice, and discusses considerations for the use of each strategy.

1. Fee-For-Service Claiming (also called Medical Assistance Service, or Direct Service Claiming)

Under fee-for-service claiming, Medicaid payments come in the form of reimbursements for services already provided. Fee-for-service claiming is essentially a process of billing the state Medicaid agency for the cost of health or mental health services which have been provided by your initiative. To the extent that you are already providing some services which may be eligible for Medicaid reimbursement, your program may be able to generate Medicaid reimbursements to pay for these services, freeing up the funds already in use for other work. If your program is not yet providing Medicaid-eligible services, Medicaid reimbursement may make it possible for your program to do so.

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Fee-for-service claiming is the most common current use of Medicaid for health and mental health services in initiatives serving school-age children and youth. It is useful to think in terms of "the three E's" when considering this approach:

- An **E**ligible provider (a mental health clinic, health care center, hospital, school system or even a department of social services, if it has the right clinical capacities), with a provider agreement with the state, *offering*
- **E**ligible services (inpatient or outpatient screening, diagnosis and treatment, laboratory, x-ray, and physician services, rural health clinics, federal health centers, dental, physical therapy, prescription drugs, eyeglasses, preventive and rehabilitative services, case management services, and many others) *to*
- **E**ligible children. (*All* children below age 20 and born after September 30, 1983, with family incomes below 100 percent of the poverty level, and *all* children up to six years with income at less than 133 percent of poverty are eligible for this broad range of services under Medicaid.)

Programs must keep very careful and detailed records on many items, including the conditions and eligibility of the children served, types and hours (or quarter hours) of service provided, the use of each staff person's time, their qualifications, and other documentation.

Claims for the costs of services are submitted to the state Medicaid Agency. (To find out how to contact your state agency, use the list of Medicaid State Directors found at the website of the American Public Health Services Association, http://medicaid.aphsa.org/members.htm.) The Medicaid agency reviews claims, adjudicates and pays them, and requests matching funds from the federal government. The federal government payments—which range from 50 percent to 83 percent—are determined by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs.

Eligible services, as long as they follow the 3-E's rule, can be configured as part of school-age children and youth initiatives, for example, counseling for children, health screenings, dental check-ups or case management.

THE PUBLIC SCHOOLS OF INDEPENDENCE, MISSOURI

Fee-for-Service Claiming in a Community School Context

The Independence School District was among the earliest to maximize Medicaid claiming, while creating a model for both out-of-school time and community school initiatives. It began in 1991, with the goal of integrating schooling and social services for children, utilizing the School of the 21st Century model. The School of the 21st Century is a community school strategy led by researchers at Yale University, that includes school-based and school-linked early care and education programs, school-age child care, and family support services.

A school district leadership team embraced the idea that schools can play an active role in promoting and ensuring the health of children. The school leaders formed a strong partnership with the state Department of Social Services to remove many barriers and obstacles in setting up and launching the program.

The program launched a series of intensive health care screenings and referrals, provided hundreds of low-income children with new services each year, and billed Medicaid for nearly $2 million in the first two years of operation. Subsequent changes in local leadership and state and federal policy resulted in a significant reduction in the volume of work paid for under Medicaid, but the program continues nearly ten years later. The Independence initiative served as an early and enterprising model of Medicaid-financed, school-based services to children.

Several elements of Independence's innovation deserve special notice:

- The infectious "can do" attitude of the school superintendent.
- Effective, powerful institutional partners.
- Strong legislative and state agency support.
- Concrete staffing commitments to launch the project, including 30 percent of the time of a senior school district leader, plus administrative support.
- A systemic approach, and manageable scale. Serving an entire school system is impressive; at 11,000 students, it is also a manageable, human scale enterprise.
- Inclusive approach to teachers and staff: 180 staff, across multiple programs, were involved in rigorous training and implementation.

For more information, contact: Debbie Marlowe, Ed.S., Assistant Superintendent of Educational Support Services, (816) 521-2999 or dmarlowe@indep.k12.mo.us.

[1] *A Strike for Independence: How a Missouri School District Generated Two Million Dollars to Improve the Lives of Children*, Center for the Study of Social Policy, May, 1994.

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I.S. 218—CHILDREN'S AID SOCIETY, NEW YORK CITY

In a long-standing partnership with the New York Public Schools, the Children's Aid Society (CAS), a comprehensive child welfare agency, provides a broad range of school-based health and mental services to children. The health clinics are part of a wide range of school-based extended day programming and family support services that comprise the CAS community school model.

Health care screening, primary care, acute care, counseling and dental services are all available on the campus of I.S. 218, a 450-student middle school, located in a low income neighborhood and attended by a population of predominately immigrant children from the Dominican Republic. Health and mental health services are available everyday, including late afternoons. All children enrolled in school may receive services, and others not attending the school—including siblings and extended family members—may also be served. Staffing includes a pediatrician, psychiatrist, dentists, nurse practitioners, medical assistants and support staff. CAS also operates school-based clinics at P.S. 5—the feeder school for I.S. 218—so that children may continue to access health care as they move from elementary to middle school.

Fee-for-service Medicaid funding partially covers the costs of the health and mental health services. In addition, New York State provides a "carve out" for these school-based programs, which means that services are covered, even though some of the children may be in enrolled in a Medicaid Managed Care HMO. CAS is a licensed Medicaid provider under the State of New York Department of Health, and is therefore, eligible to bill for a range of Medicaid-eligible services. Although I.S. 218's student body is overwhelmingly Medicaid-eligible, and outreach efforts to enroll additional children are ongoing and aggressive, only 35 percent of the students are enrolled in Medicaid. However, even with a low rate of enrollment, the school generates approximately $247,000 in Medicaid reimbursements annually.

In the nine years that these health and mental health services have been provided, significant results have been achieved: 1130 children receive health, mental health and/or dental services each year, covering approximately 62 percent of the students in the school. Overall health and mental health indicators have improved, including higher immunization rates, more frequent periodic check-ups, new nutritional assessments, diagnosis of previously unknown vision and hearing problems, asthma management, and treatment for childhood depression and phobias. I.S. 218 has experienced a reduction in school violence and disciplinary problems, and an on-going increase in the level of student attendance. Student test scores have also shown measurable improvement.

The Medicaid fee-for-service income serves as a critical base of program funding and covered 46 percent of the school's health and dental budget in the year 1999. Without this income, CAS could not employ a substantial number of its current clinical staff. Other partnerships and resources support I.S. 218 health and wellness services and allow the school to offer an increasing range of services. For example, one recent partnership with a local psychoanalytic institute is helping to provide school-wide screening for childhood depression; another partnership may soon enable the school to offer optometry services. CAS administrators note that partnerships between Medicaid-eligible providers and public schools yield a variety of benefits: (1) lower no-show rates, (2) lower costs, and (3) an opportunity to reach more children and youth.

For more information, contact: James Langford, Quality Assessment Manager, (212) 949-4953 or jamesl@childrensaidsociety.org.

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Considerations:

- This approach is best for those organizations or partnerships which are already equipped with a clinical capacity. It is fairly straightforward for an organization which already has a track record of clinical service provision and authorization to bill the state Medicaid agency for new mental health or health care services for school-age children and youth with this kind of Medicaid funding. For an agency or partnership lacking such clinical capacity, however, it is advisable either to build such capacity into one's organization, or, perhaps more practically, to seek out a partnership with a qualified, experienced agency.
- Providers should anticipate and plan for the cashflow crunch inherent in waiting for government funds, and should budget start-up or interim funding resources well in advance. Fee-for-service billing requires some kind of up-front funding for staff costs prior to receipt of reimbursements. The funding for up-front staff costs may come from reserve funds, grants, "advances" from the state agency, core staffing salaries covered by other revenue, or funds made available by a partner agency.
- Initiatives will have to determine if the fee-for-service reimbursement rates are worth the trouble to claim. Rates of reimbursement are set not by the federal government, but by each state Medicaid agency. These rates therefore vary significantly, both within different areas of a single state's Medicaid program, and from state to state. Providers will want to know in advance just how much they can expect in reimbursements from the state for each specific service they provide.
- In many states, high levels of administrative and record-keeping organization, reporting detail and interpretation of changing policies and rulings are required. These can be challenging, and costly, to a provider.
- Like each of the approaches that follow, fee-for-service reimbursements work best—and are far more likely to be successful and productive—if they are designed in a collaborative fashion, with local and state agency involvement, approval and ongoing interaction.

2. Administrative Claiming

Many school staff activities that are related to students' health and mental health are reimbursable through Medicaid, under a system called administrative claiming. Throughout the recently released *Medicaid School-Based Administrative Claiming Guide*,[3] there is a consistent emphasis on the federal government's willingness to fund health- and mental health-related collaboration, interagency work, planning, referrals, and case management. Significantly, costs for most of these activities are usually not reimbursable under fee-for-service claiming. Also, these activities are often the very things that are hardest to fund—by any means—in initiatives serving school-age children and youth.

One great difference, and advantage, of administrative claiming over fee-for-service claiming is that the costs for large amounts of work performed by local agency staff to support the health or mental health of children can be claimed without painstaking documentation of every minute of every service provider's time. By using a formula, or calculation, for arriving at the relevant proportion of time of those staff who are involved, administrative claiming processes make it possible to claim for the costs of a very large volume of work performed, with a fraction of the paperwork of fee for service claiming.[4]

[3] *Medicaid School-Based Administrative Claiming Guide*, Health Care Financing Administration, February, 2000. For a copy of the guide, see http://www.hcfa.gov/medicaid/schools/machmpg.htm.

[4] A typical process includes the creation of activity codes, sampling of staff activity through time studies, and rate calculation formulae. All activities, reimbursable and not, are given a code. School staff participate in a periodic time study, typically a whole day in which everyone codes their activity every 15 minutes. This gives a proportional picture of the use of everyone's time, which is used to calculate reimbursement rates. These rates are sometimes called "bundled" for the way in which they package a variety of functions in a single claim for reimbursement.

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Although there is considerable logistical complication in setting up such a program, administrative claiming has the advantage of being less labor intensive than fee-for-service claiming once it is underway. It also offers the considerable benefit of funding a wide range of activities which are not direct health or mental health services, many of which lend themselves to health and mental health programming for school-age children and youth.

The range of activities eligible for administrative claiming is quite broad, and can include:

- **Medicaid Outreach.** Agencies can recover the costs of identifying, contacting, informing, referring and updating families and children who are Medicaid eligible about their eligibility and the program benefits to which they are entitled. Training for outreach staff on how to assist families, effectively refer students, and other functions is among the reimbursable expenses. In Washington state, this form of claiming now generates Medicaid reimbursements to more than half of all school districts.

- **Facilitating Medicaid Enrollment**. The costs of helping people apply for Medicaid, gathering information, and providing and preparing forms are reimbursable under administrative claiming.

- **Transportation and Translation Services**. When offered in connection with provision of Medicaid-covered services, these costs can also be claimed—by school systems, mental health agencies, and others.

- **Special Education Services**. One of the largest and most popular examples of school-based administrative claiming strategies is the increasingly common practice of claiming reimbursement for the costs of mental health and other services performed by the special education programs of local schools. For years, many school systems have provided these services to Medicaid-eligible children, often with state assistance, without ever receiving Medicaid funding of any kind. With the advent of this kind of claiming, some school systems are accessing millions in federal matching funds, while in other cities and states, such claiming has yet to take place.

- **Program Planning, Interagency Collaboration, Strategy and Policy Development**. When they are related to Medicaid-covered health and mental health services, costs can be reimbursed, and federal matching funds secured, for activities which are not direct services. These can include: identifying gaps/duplication in services; monitoring current delivery systems; assessing needs for Medicaid services; improving collaboration between Medicaid providers; developing advisory teams of health professionals; developing medical referrals sources; and coordinating with interagency bodies to promote and develop EPSDT services in schools.

- **Referral, Coordination and Monitoring of Medicaid Services (also called Administrative Case Management)**. This function can include: identifying and referring adolescents who may need family planning services; referring/coordinating health exams and mental health evaluations; making referrals for screening and immunizations; gathering information in advance of referrals; coordinating student services with other agencies; doing follow-up to ensure delivery of services; ensuring continuity of care in transitions; monitoring and evaluating Medicaid service components of student Individual Education Plans (IEP); and coordinating with managed care plans as appropriate.

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MINNESOTA'S ADMINISTRATIVE CLAIMING STRATEGY

In 1995, Minnesota piloted a project for increasing Medicaid reimbursements to support new, locally planned interagency collaborations called Family Services and Children's Mental Health Collaboratives. These new entities, whose work often includes out-of-school-time and community-school strategies, are voluntarily established by teams of local and state officials, legislators, and non-profits and foundations. The incentive for local education and social services leaders to enter into these new planning and programming alliances—another significant demand on their time and resources—was that substantial funding was attached. New state grants for planning and implementation would flow only to those communities which had set up these collaboratives. Funding for these new state grants was provided through increased federal Medicaid payments to the state for services delivered in local Minnesota communities.

Through a painstaking process of planning and negotiation, the state created a streamlined process by which many of its local public agencies could file administrative claims for case coordination and outreach services delivered to Medicaid-eligible children. These new claims generate substantial new federal revenue. Further, since Minnesota's own state and local non-Medicaid funds have already paid the cost of the services for which the federal matching payment is made, there is no additional cost to the state.

Minnesota expanded its claiming capability to include not only public schools systems, but also public health and corrections programs as well. Whereas many states are now actively encouraging school systems to participate in administrative claiming, it is very unusual to see such a broad, inclusive approach.

Instead of channeling federal Medicaid funds directly back to the school systems or local communities that generated them, the state pools all matching funds in a single state fund. It then makes funds available to any local community that has made the effort to develop a Family Services and Children's Mental Health collaborative. Funds must be used to expand early intervention and prevention services for children and families, and are available to any community that creates a collaborative and provides documentation to support ongoing federal claims.

The Minnesota approach, like others profiled, highlights an important feature of some Medicaid-driven reforms and initiatives: Medicaid funds can often be very flexibly applied. As long as claims are filed for eligible clients, by eligible providers, offering eligible services, the actual use of the matching funds when they arrive is up to the discretion of the recipient under state policy. Minnesota, with the leadership of its legislature and the support of the federal government, has used this flexibility to make a leading edge commitment of funds to the expansion of early intervention and prevention services at the local level.

For more information, contact: Jamie Halpern, Hennepin County Human Services Administration, (612) 348-9259.

Considerations:

- Administrative claiming has the potential to become a reliable source of funding for staff whose work encompasses some of the hardest things to fund—collaboration, interagency communication, partnership, and case management.
- Record keeping for administrative claiming, under the right circumstances, can be substantially less complex or demanding than fee-for-service claiming. State agencies often create a rate calculation formula process for school staff. Although time consuming in the set-up stages, this system actually saves school staff and their clinical partners significant time, since it requires intensive record-keeping only periodically, rather than on a daily basis.
- Reporting requirements are set by both the Health Care Financing Administration (HCFA), and each state Medicaid agency. States are increasingly making the effort to simplify reporting and administrative requirements associated with this claiming

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function, in the hope of encouraging maximum participation by school systems, in particular. The administrative burden of this approach will depend on each state's system—in states with streamlined systems, these difficulties have been substantially reduced.

- As with fee-for-service claiming, care must be taken never to submit claims for the cost of services that have been paid for with other Medicaid funds, or by another federal source. This is a common mistake, and often results in audits, unfavorable rulings from state and federal Medicaid agencies, and mandatory repayments of overclaimed or improperly claimed amounts.
- States have great flexibility to use dollars generated through administrative claiming to accomplish a wide range of goals. Much variation exists in the way states plan, manage and use administratively claimed funds. For example, under a Massachusetts law passed in the early nineties, federal matching payments are made not to the school systems in whose Special Education programs the Medicaid-eligible services were provided, but to that school system's municipal government, with no requirement that funds be used for children, for health care, or even for human services. This process creates great flexibility for city managers and mayors, but with no requirement that the funds be earmarked for health care or even for children, there is no guarantee that resources reach children and families who need them. In Minnesota, by contrast, the state has mandated that all administratively claimed federal matching funds flow to a statewide agency, which then disburses these federal funds back to communities for use in interagency, community-based, family strengthening programs. (See Minnesota example for details.)
- Finally, the administrative claiming approach can have great appeal to governors, state agencies and state legislatures for the simple reason that it costs states nothing extra. More often then not, this kind of administrative claiming is based on pre-existing state and local Special Education spending or other state expenditures. Because the state has already paid the cost, administrative claiming does not trigger any additional outlay of resources by the state to qualify for the federal Medicaid match.

3. "Leveraged" Funding—Partnerships That Maximize Medicaid Reimbursements

Another strategy to maximize Medicaid funding is for two or more agencies to create a formal partnership to 'leverage' new or additional Medicaid funding. Leveraged funds are generated through an agreement between two or more agencies, at least one of which has access to Medicaid reimbursement funds, and at least one of which has access to other non-Medicaid funds and resources. Alone, neither the Medicaid-certified agency nor the ineligible agency can generate new revenue; together, they can.

In this brief, each example of this model involves a public school system and a large public mental health agency, which serves as the fiscal intermediary for the state Medicaid program at the local level. In both of the following examples, the participating agencies share a vision and commitment to change their policies and practices to expand services to children and families. The first partner agency—or team of agencies—has the capability to develop a set of Medicaid eligible activities. It brings a variety of non-Medicaid resources to the table—funding, services for children, staffing—but lacks the necessary Medicaid certification to make claims for reimbursements that would enable it to serve more children or provide a higher level of services.

The second partner agency—in each of the case studies, the Los Angeles Department of Mental Health—is the official local program/fiscal intermediary for the state Medicaid program, but finds itself either not in a position to provide the desired additional services directly, or wishing to extend its services through a 'blended' or leveraged funding mechanism. By working together, the partners are able to generate additional services to more children.

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LOS ANGELES UNIFIED SCHOOL DISTRICT—REINVESTING ITS OWN GENERAL FUNDS:

For years, the Los Angeles Unified School District (LAUSD) had been spending its general fund, state- and locally-generated funds on the provision of mandated mental health services to children, without accessing Medicaid funding through EPSDT. In 1992, the school system was approached by the Los Angeles (LA) County Department of Mental Health, whose interest was in increasing services in the community.

By becoming a contract agency through a partnership with the LA County Department of Mental Health, the school system was able to become a certified EPSDT Medicaid provider. The school district is now able to claim Medicaid reimbursement for many services to children that it used to provide using its general funds. In turn, it now uses its general fund dollars to pay for services to children who are not Medicaid-eligible. The LA County Department of Mental Health is able to extend its services to this needy but underserved population—approximately two-thirds of the 1.1 million student body are not Medicaid eligible. The net result: a win-win situation for both organizations, with expanded resources to provide a larger number of children with increased services.

In the LAUSD model, no cash commitment is made by the LA County Department of Mental Health. They provide the school system with access to Medicaid certification, technical assistance, and some monitoring functions. In return, the school system is able to serve many more students' mental health needs.

The size of the LAUSD is an important factor in this model. For more than 60 years, LAUSD has offered clinical services to children. When its clinic had an opportunity to become Medicaid-certified to treat children whose conditions meet the stringent "medical necessity" requirements of Medicaid, the resources and infrastructure for providing mental health services were already in place within the LAUSD. Officials of the school system point out that Medicaid has improved the overall quality of services delivered, through its stringent quality assurance standards, exacting clinical expectations and requirement for clear therapeutic objectives.

Last year, some $2 million in general fund expenditures by the LAUSD leveraged an additional $850,000 in EPSDT Medicaid reimbursements, serving a total of 10,000 children. A hallmark of this effort is that LAUSD has maintained or increased its level of general fund spending. Such "maintenance of effort" is a key element in ensuring that a larger pool of children is served, or that additional and better services are delivered.

For more information, contact: Marleen Wong, Los Angeles Unified School District, (818) 997-2640.

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PASADENA UNIFIED SCHOOL DISTRICT—A SCHOOL-COMMUNITY-COUNTY ALLIANCE

The Pasadena Unified School District serves 23,000 students in Southern California, 46 percent of whom are Medicaid-eligible. Despite this relatively high number of Medicaid-eligible students (more than twice the national average), as recently as 1998, few students were receiving Medicaid services through school-based programming. A strong cohort of community-based mental health agencies was offering a broad array of services outside of the Pasadena schools. The local Los Angeles County Mental Health department began to play a leading role in encouraging school and community partnerships to make sure that more children received the services they needed.

Through a careful process of negotiations, the Pasadena Unified School District and the LA County Mental Health Department jointly crafted a new approach to school-based mental health care. By awarding or increasing contracts to a total of six non-profit community-based mental health providers—all of whom are Medicaid-certified—the LA County Mental Health Department enabled the Pasadena schools to greatly increase services. Using a model in which up to 40 families per year are served by a team made up of a clinician and a case manager, this multi-partner approach reached 1,500 students from 5 to 18 years old, in 32 different schools, in the 1999-2000 school year. Medicaid-eligible children, SCHIP-eligible children and children who are eligible for neither program are all served.

Financing for this innovative model comes from four sources:

- Medicaid reimbursements (exclusively for Medicaid-eligible children) were allocated to cover approximately 57 percent of the $4.7 million project costs projected for the past year;
- A modest proportion of SCHIP funding is recovered whenever an SCHIP-eligible child is served;
- The Pasadena schools contribute tens of thousands of dollars in in-kind services, clerical support, space, and infrastructure; and
- Most significantly, the LA County Department of Mental Health covers the costs of serving those children who are eligible for neither Medicaid nor SCHIP.

In the 1999-2000 year, some $2 million in county mental health "gap" funding was made available for this purpose. (Actual spending was less, due to start-up and logistical considerations.)

Officials in both the LA County Mental Health office and the Pasadena public schools view this partnership as a way to encourage and accelerate a broad range of additional school-community alliances and programs. For example, 16 of the 32 schools in which these services were first offered are recently established 21st Century Community Learning Center sites, incorporating a vision of partnership between schools and community agencies that is a basic principle in many out-of-school-time and community school initiatives. Pasadena officials hope that working together at the same sites will enable these Medicaid and out-of-school time projects to reinforce and strengthen one another.

For more information, contact: Jackie Acosta, Ph.D. Los Angeles County Department of Mental Health, (213) 738-3115.

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Considerations:

- A high level of trust and communication and a carefully constructed arrangement between partner agencies is essential in any leveraged funding approach.
- Like some forms of administrative claiming, this approach can have the great advantage of costing the states little or nothing—if a claim for federal reimbursement is made which documents the existing investment of the state in the original expenditure, then the only new expenditures being made are those of the federal government.
- Leveraged funding also contributes to the development of integrated systems of care. The typical leveraged funding project is possible only when two or more partner agencies have sufficient trust to engage in the transfer of large dollar amounts and the creation of a common agenda. For many out-of-school time and community school leaders, this inter-agency collaborative approach is a familiar one.
- Leveraged funding doesn't always increase funding—in times of cuts, it may simply be a tool for minimizing reductions in service.
- Partners and advocates planning such leveraged ventures should consider creating a "maintenance of effort" agreement to ensure that Medicaid funds do not act to supplant other funds, with no net increase in resources for children and families. Achieving a net increase in resources committed to the well-being of children and families is a useful standard to observe.

4. Building Statewide Systems to Integrate Services & Improve Outcomes

Much of the real action on the national Medicaid agenda—congressional and federal administrative activity notwithstanding—is in the states. States set their own rates of reimbursement, their own processes for determining service and provider eligibility, and their own procedures for claiming. Equally as important, they set a tone that reflects their philosophical view, and influences the practices of their agencies, throughout each state.

State Medicaid practices span a broad spectrum. A small group of states, including Vermont (see box) have adopted a consistent emphasis on expanding or strengthening government's role in promoting the public health, advancing child development, and delivering comprehensive services. These states use Medicaid spending as a lever for their larger objectives. A large cohort of states view Medicaid as a potential threat to containing costs and limiting state spending, and approach any Medicaid spending or claiming plan with caution. Finally, a smaller group of states have taken a highly skeptical approach, ignoring opportunities to draw down even those federal Medicaid matching payments to which they and the low income children of their state are entitled by virtue of existing allocations and state expenditures on services that could be claimed.

There is great power—and much untapped potential—in Medicaid state agencies for increasing access, promoting new program venues for services, setting a statewide agenda for children's health, and promoting strong interagency partnerships. In some states, such as Vermont, Minnesota and Washington, budgeting for Medicaid allocations across the state becomes an annual process of predicting the state share in an ever increasing Medicaid reimbursement pool, and using that planned state investment to maximize the federal return, while producing higher quality outcomes for children. Some of these funds already find their way into initiatives serving school-age children and youth. Should states increasingly adopt this kind of deliberate, strategic approach to maximizing federal support for Medicaid services and activities, there is great potential for generating much more funding to support services for low income children while significantly expanding and strengthening out-of-school time and community school program approaches.

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VERMONT'S STATEWIDE SCHOOL-BASED APPROACH

In Vermont, regional non-profit prevention partnerships team up with public schools to provide a wide range of school-based services with Medicaid funding. Using a combination of fee-for-service reimbursements, administrative claiming for special education, outreach, and other services, Vermont knits together several Medicaid federal matching strategies to truly maximize federal support for children's health.

This model uses a statewide public-private strategy, through which a team of regional/county non-profit prevention and partnership agencies collaboratively sets a variety of program and outcome goals *in partnership with* the state Medicaid agency and the state department of education. In this way, the state is able to plan for and budget both state reimbursements and federal matching fund payments. With this advance planning and guidance, local agencies have an increased ability to do long-term strategic program development, staffing and improvement.

Elements of the approach:

- A focus on outcomes and accountability seeks out improvements, produces evidence of impact, increases program credibility, and strengthens the public's support.
- A strong alliance between the Vermont Department of Education and the Vermont Medicaid agency, formed over a decade ago, drives planning and policy.
- People at many levels in the state bureaucracies have made long-term commitments to prevention, early intervention, and increased health and mental health services.
- Statewide systems are in place for interagency collaboration, both among private non-profits and between non-profits and state and local public agencies.
- Public schools are, by widespread consensus, placed at the center of an interagency collaborative approach.
- State and local agencies participate in shaping an annually reviewed statewide plan.
- Legislators, agency heads and the Governor provide strong leadership.

For more information, contact: Christopher Mulvaney, Administration for Human Services, (802) 241-2235.

Considerations:

- Creating a comprehensive statewide system can provide a powerful impetus to maximize federal funding sources and improve coordination and integration of supports and services for children, youth and families.
- Putting a statewide system in place can be difficult and costly. Comprehensive approaches require strong, sustained leadership in the public sector, broad partnerships across bureaucratic and policy boundaries, and considerable community investment and buy-in.

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CONCLUSION

Medicaid offers intriguing opportunities for organizations at any point along a spectrum of experience with health and mental health services for school-age children and youth. Depending on their experience, interests and resources, planners and advocates can consider modest local approaches or sweeping statewide ventures. Some examples include:

- Program developers who are entering the first stages of program planning and formation, for example, may consider a simple fee-for-service arrangement as a way to ease in to the work and to master the complexities of Medicaid.
- Policy makers in city government could support an array of services provided in community school contexts, generating funding simply by re-allocating some of the substantial pre-existing federal Medicaid matching payments over which they have discretionary power.
- School systems might choose to begin with the expansion of proven programs from pilot sites to other schools, using a leveraging approach in partnership with those agencies which have successfully developed the pilots.
- A superintendent with a vision for substantially increased community school programming could begin a discussion with colleague districts and the state Medicaid agency about ways to leverage additional federal funds through a more coordinated, statewide approach.

The options, and the variations on these and other approaches, are virtually limitless.

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Understanding Medicaid, Phyllis A. Doran, Dennis J. Hulet, David F. Ogden, Milliman and Robertson (1995).

A Strike for Independence: How a Missouri School District Generated Two Million Dollars to Improve the Lives of Children, Center for the Study of Social Policy (1994).

Contact Information for Resources

American Public Health Services Association
810 First Street, NE, Suite 500
Washington, DC 20002-4267
(202) 682-0100
http://medicaid.aphsa.org/members.htm

Center for the Study of Social Policy
1250 Eye Street, NW, Suite 503
Washington D.C. 20005
(202) 371-1565
http://www.cssp.org

Health Care Financing Administration
http://www.hcfa.gov/medicaid/medicaid.htm

Murphy's Unofficial Medicaid Page
http://www.geocities.com/CapitolHill/5974/

National Health Law Program
1101 14th Street, NW, Suite 405
Washington, DC 20005
(202) 289-7661
http://www.healthlaw.org

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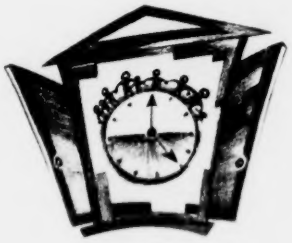
The Finance Project

The Finance Project is a non-profit policy research, technical assistance and information organization that was created to help improve outcomes for children, families, and communities nationwide. Its mission is to support decision making that produces and sustains good results for children, families, and communities by developing and disseminating information, knowledge, tools, and technical assistance for improved policies, programs, and financing strategies. Since its inception in 1994, The Finance Project has become an unparalleled resource on issues and strategies related to the financing of education and other supports and services for children, families, and community development.

The Out-of-School Time Technical Assistance Project

This tool is part of a series of technical assistance resources on financing and sustaining out-of-school time and community school initiatives developed by The Finance Project with support from the Wallace-Reader's Digest Funds. These tools and resources are intended to assist policy makers, program developers and community leaders in developing financing and sustainability strategies to support effective out-of-school time and community school initiatives.



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